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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00542

100

Reg. Dist. No.....

546

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		STATE <i>Md.</i> COUNTY <i>Charles</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		TOWN <i>Waldorf</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <i>Route 2 Box 118</i>		ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St. Mary's Hosp.</i>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>JAMES A. ARNISON</i>				<i>Jan 7 1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>12-18-88</i>	9. AGE last birthday <i>68</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Pepsi Employee</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Adolph Arnison</i>				14. MOTHER'S MAIDEN NAME <i>Emma Taylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>		17. INFORMANT & ADDRESS <i>Emma L. Birchhead - sister</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <i>Cong. St. Failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1-5-57</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Report urine tract disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1-5-57</i> , to <i>1-7-57</i> , that I last saw the deceased alive on <i>1-7-57</i> , and that death occurred at <i>10:25</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>J. H. Hodeler</i> M.D.				DATE SIGNED <i>Jan 11 1957</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 11 1957</i>		NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>	
24. REC'D BY REGISTRAR <i>Jan 11 1957</i>		REGISTRAR'S SIGNATURE <i>Julia Posey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i>		ADDRESS <i>Wash., D.C.</i>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH	
9. MEDICAL HISTORY		10. MANNER OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER	
15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE	
21. SIGNATURE OF JAILER		22. SIGNATURE OF PRISONER	
23. SIGNATURE OF WARDEN		24. SIGNATURE OF CHIEF CLERK	
25. SIGNATURE OF CHIEF OF POLICE		26. SIGNATURE OF CHIEF OF FIRE DEPARTMENT	
27. SIGNATURE OF CHIEF OF SANITARY DEPARTMENT		28. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT	
29. SIGNATURE OF CHIEF OF MENTAL HYGIENE DEPARTMENT		30. SIGNATURE OF CHIEF OF EYE, EAR, AND NOSE DEPARTMENT	
31. SIGNATURE OF CHIEF OF DENTAL DEPARTMENT		32. SIGNATURE OF CHIEF OF VETERINARY DEPARTMENT	
33. SIGNATURE OF CHIEF OF LABORATORY		34. SIGNATURE OF CHIEF OF PHARMACY	
35. SIGNATURE OF CHIEF OF HOSPITAL		36. SIGNATURE OF CHIEF OF DISPENSARY	
37. SIGNATURE OF CHIEF OF CLINIC		38. SIGNATURE OF CHIEF OF OUTPATIENT DEPARTMENT	
39. SIGNATURE OF CHIEF OF INPATIENT DEPARTMENT		40. SIGNATURE OF CHIEF OF NURSING DEPARTMENT	
41. SIGNATURE OF CHIEF OF X-RAY DEPARTMENT		42. SIGNATURE OF CHIEF OF RADIOLOGY DEPARTMENT	
43. SIGNATURE OF CHIEF OF PATHOLOGY DEPARTMENT		44. SIGNATURE OF CHIEF OF BACTERIOLOGY DEPARTMENT	
45. SIGNATURE OF CHIEF OF ANATOMY DEPARTMENT		46. SIGNATURE OF CHIEF OF PHYSIOLOGY DEPARTMENT	
47. SIGNATURE OF CHIEF OF CHEMISTRY DEPARTMENT		48. SIGNATURE OF CHIEF OF BOTANY DEPARTMENT	
49. SIGNATURE OF CHIEF OF ZOOLOGY DEPARTMENT		50. SIGNATURE OF CHIEF OF AGRICULTURE DEPARTMENT	
51. SIGNATURE OF CHIEF OF FISHERIES DEPARTMENT		52. SIGNATURE OF CHIEF OF FORESTRY DEPARTMENT	
53. SIGNATURE OF CHIEF OF MINING DEPARTMENT		54. SIGNATURE OF CHIEF OF MANUFACTURES DEPARTMENT	
55. SIGNATURE OF CHIEF OF COMMERCE DEPARTMENT		56. SIGNATURE OF CHIEF OF TRANSPORTATION DEPARTMENT	
57. SIGNATURE OF CHIEF OF EDUCATION DEPARTMENT		58. SIGNATURE OF CHIEF OF PUBLIC WORKS DEPARTMENT	
59. SIGNATURE OF CHIEF OF SOCIAL WELFARE DEPARTMENT		60. SIGNATURE OF CHIEF OF LABOR RELATIONS DEPARTMENT	
61. SIGNATURE OF CHIEF OF EMPLOYMENT DEPARTMENT		62. SIGNATURE OF CHIEF OF UNEMPLOYMENT DEPARTMENT	
63. SIGNATURE OF CHIEF OF VETERANS DEPARTMENT		64. SIGNATURE OF CHIEF OF ELDERLY DEPARTMENT	
65. SIGNATURE OF CHIEF OF YOUTH DEPARTMENT		66. SIGNATURE OF CHIEF OF WOMEN DEPARTMENT	
67. SIGNATURE OF CHIEF OF CHILDREN DEPARTMENT		68. SIGNATURE OF CHIEF OF INFANTS DEPARTMENT	
69. SIGNATURE OF CHIEF OF ADULTS DEPARTMENT		70. SIGNATURE OF CHIEF OF SENIORS DEPARTMENT	
71. SIGNATURE OF CHIEF OF DISABLED DEPARTMENT		72. SIGNATURE OF CHIEF OF MENTALLY ILL DEPARTMENT	
73. SIGNATURE OF CHIEF OF PHYSICALLY ILL DEPARTMENT		74. SIGNATURE OF CHIEF OF MENTALLY SOUND DEPARTMENT	
75. SIGNATURE OF CHIEF OF PHYSICALLY SOUND DEPARTMENT		76. SIGNATURE OF CHIEF OF MENTALLY SOUND DEPARTMENT	
77. SIGNATURE OF CHIEF OF PHYSICALLY SOUND DEPARTMENT		78. SIGNATURE OF CHIEF OF MENTALLY SOUND DEPARTMENT	
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93. SIGNATURE OF CHIEF OF PHYSICALLY SOUND DEPARTMENT		94. SIGNATURE OF CHIEF OF MENTALLY SOUND DEPARTMENT	
95. SIGNATURE OF CHIEF OF PHYSICALLY SOUND DEPARTMENT		96. SIGNATURE OF CHIEF OF MENTALLY SOUND DEPARTMENT	
97. SIGNATURE OF CHIEF OF PHYSICALLY SOUND DEPARTMENT		98. SIGNATURE OF CHIEF OF MENTALLY SOUND DEPARTMENT	
99. SIGNATURE OF CHIEF OF PHYSICALLY SOUND DEPARTMENT		100. SIGNATURE OF CHIEF OF MENTALLY SOUND DEPARTMENT	

BUREAU V. S.

JAN 11 1957

RECEIVED

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00543

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHARLES</u> <b>COUNTY</b> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RURAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN</u> d. STREET ADDRESS <u>None - RURAL</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JAMES</u> Middle <u>A.</u> Last <u>BUTLER</u>				<b>4. DATE OF DEATH</b> Month <u>1</u> - Day <u>26</u> Year <u>1957</u>													
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-21-20</u>		<b>9. AGE</b> (In years last birthday) <u>36</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARMING</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>James A. Butler Sr.</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Tolson</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212 24 2672</u>		<b>17. INFORMANT</b> <u>WIFE</u> Address <u>MRS JAMES BUTLER - BRYANTOWN</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON MONOXIDE POISONING</u> <u>9160</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE ALCOHOLISM</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Overcome by Smoke - Conflagration in home</u>													
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>1-26-1957</u> Hour <u>3</u> a. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>home</u>		<b>20f. (City or town)</b> <u>BRYANTOWN-CHAS. MD</u>		<b>20g. (County)</b> <u>MD</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <u>Russell S. Fisher</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>1/27/57</u>									
<b>EXAMINER'S NAME (Type)</b> <u>Russell S. Fisher</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>1-24-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Mary's Cem. Bryantown, MD</u>		<b>22d. LOCATION (City, town, or county)</b> <u>MD</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Funeral Home Waldorf, Md.</u>				<b>ADDRESS</b>		<b>24a. RECEIVED BY REGISTRAR</b> <u>Julius [Signature]</u>		<b>24b. REGISTRAR'S SIGNATURE</b>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages J and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 29 1957

RECEIVED

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A carbon copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

548

## CERTIFICATE OF DEATH

00544

Reg. Dist. No. 100

1. PLACE OF DEATH <i>Charles County</i>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Spartanburg</i>		MARYLAND		STATE		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Walter (Middle) MATION (Last)</i>				4. DATE OF DEATH <i>12-57</i> 19 <i>57</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>4-21-06</i>	9. AGE last birthday <i>51</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Charles Co mcd.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>THOMAS COLE</i>				14. MOTHER'S MAIDEN NAME <i>MARY Jenkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
571.0 IMMEDIATE CAUSE (A) <i>Pneumonia Gram.</i>				12-31-56			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				12-29-56			
STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> et work <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12-29-56</i> , to <i>1-2-57</i> , that I last saw the deceased alive on <i>1-2-57</i> , and that death occurred at <i>2:11</i> M, from the causes and on the date stated above.							
SIGNATURE <i>W. J. Delaney</i>		M.D.		ADDRESS (Street, city, town, state) <i>1-2-57</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 4 1957</i>		NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		LOCATION (City, town, or county) (State) <i>New Port mcd.</i>	
24. REC'D BY REGISTRAR <i>Julia H. Posen</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Inc</i>		ADDRESS <i>Spartanburg mcd.</i>	

4000 206XV6



# CERTIFICATE OF DEATH

Form 100-1-57

1. DECEASED'S NAME (Last, first, middle initial)

2. PLACE OF DEATH

3. SEX  
4. AGE  
5. DATE OF BIRTH  
6. PLACE OF BIRTH  
7. OCCUPATION  
8. MARITAL STATUS  
9. EDUCATION  
10. RELIGION  
11. RACE  
12. COLOR  
13. ETHNIC ORIGIN

14. SEX

15. DATE OF DEATH  
16. TIME OF DEATH  
17. PLACE OF DEATH  
18. CAUSE OF DEATH  
19. MANNER OF DEATH  
20. MEDICAL HISTORY  
21. PREVIOUS ILLNESS  
22. PREVIOUS SURGERY  
23. PREVIOUS TRAUMA  
24. PREVIOUS DRUGS  
25. PREVIOUS ALCOHOL  
26. PREVIOUS TOBACCO  
27. PREVIOUS OTHER

28. SIGNATURE OF DECEASED  
29. SIGNATURE OF WITNESS  
30. SIGNATURE OF PHYSICIAN  
31. SIGNATURE OF CLERK  
32. SIGNATURE OF REGISTRAR  
33. SIGNATURE OF JUDGE  
34. SIGNATURE OF SHERIFF  
35. SIGNATURE OF CORONER  
36. SIGNATURE OF DISTRICT ATTORNEY  
37. SIGNATURE OF COUNTY ATTORNEY  
38. SIGNATURE OF STATE ATTORNEY  
39. SIGNATURE OF U.S. ATTORNEY  
40. SIGNATURE OF FEDERAL JUDGE  
41. SIGNATURE OF FEDERAL CLERK  
42. SIGNATURE OF FEDERAL DEPUTY CLERK  
43. SIGNATURE OF FEDERAL DEPUTY U.S. ATTORNEY  
44. SIGNATURE OF FEDERAL DEPUTY DISTRICT ATTORNEY  
45. SIGNATURE OF FEDERAL DEPUTY COUNTY ATTORNEY  
46. SIGNATURE OF FEDERAL DEPUTY STATE ATTORNEY  
47. SIGNATURE OF FEDERAL DEPUTY U.S. ATTORNEY  
48. SIGNATURE OF FEDERAL DEPUTY DISTRICT ATTORNEY  
49. SIGNATURE OF FEDERAL DEPUTY COUNTY ATTORNEY  
50. SIGNATURE OF FEDERAL DEPUTY STATE ATTORNEY

51. SIGNATURE OF DECEASED

52. SIGNATURE OF WITNESS

53. SIGNATURE OF PHYSICIAN

54. SIGNATURE OF CLERK

55. SIGNATURE OF REGISTRAR

56. SIGNATURE OF JUDGE

57. SIGNATURE OF SHERIFF

58. SIGNATURE OF CORONER

59. SIGNATURE OF DISTRICT ATTORNEY

60. SIGNATURE OF COUNTY ATTORNEY

61. SIGNATURE OF STATE ATTORNEY

62. SIGNATURE OF U.S. ATTORNEY

63. SIGNATURE OF FEDERAL JUDGE

64. SIGNATURE OF FEDERAL CLERK

65. SIGNATURE OF FEDERAL DEPUTY CLERK

66. SIGNATURE OF FEDERAL DEPUTY U.S. ATTORNEY

67. SIGNATURE OF FEDERAL DEPUTY DISTRICT ATTORNEY

68. SIGNATURE OF FEDERAL DEPUTY COUNTY ATTORNEY

69. SIGNATURE OF FEDERAL DEPUTY STATE ATTORNEY

70. SIGNATURE OF FEDERAL DEPUTY U.S. ATTORNEY

71. SIGNATURE OF FEDERAL DEPUTY DISTRICT ATTORNEY

72. SIGNATURE OF FEDERAL DEPUTY COUNTY ATTORNEY

73. SIGNATURE OF FEDERAL DEPUTY STATE ATTORNEY

74. SIGNATURE OF FEDERAL DEPUTY U.S. ATTORNEY

75. SIGNATURE OF FEDERAL DEPUTY DISTRICT ATTORNEY

76. SIGNATURE OF FEDERAL DEPUTY COUNTY ATTORNEY

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90. SIGNATURE OF FEDERAL DEPUTY U.S. ATTORNEY

91. SIGNATURE OF FEDERAL DEPUTY DISTRICT ATTORNEY

92. SIGNATURE OF FEDERAL DEPUTY COUNTY ATTORNEY

93. SIGNATURE OF FEDERAL DEPUTY STATE ATTORNEY

94. SIGNATURE OF FEDERAL DEPUTY U.S. ATTORNEY

BUREAU Y. S.

JAN 10 1957

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

549

## CERTIFICATE OF DEATH

00545

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spring Hill</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Male</u> (First) <u>Infant</u> (Middle) <u>Cooksey</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>January</u> (Day) <u>16</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>January 16, 1957</u>	9. AGE last birthday yrs. <u>1</u> mos. <u>5</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>La Plata, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Rudolph Cooksey</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Ann Ray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Howard Cooksey, Spring Hill, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Prematurity, not consistent with survival (5 1/2 mos.) 1' 5"</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Weight 1 lb, 10 oz.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-16-57</u> , 19 <u>57</u> , to <u>1-16-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-16-57</u> , 19 <u>57</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John H. Griffin, M.D.</u>				ADDRESS (Street, city, town, state) <u>Hughesville, Md.</u>			
DATE SIGNED <u>1-16-57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-17-57</u>		NAME OF CEMETERY OR CREMATORY <u>Dentsville, M.E.</u>		LOCATION (City, town, or county) (State) <u>Spring Hill, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>1/17/57</u>		REGISTRAR'S SIGNATURE <u>Julia H. Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Beckhart Inc. La Plata, Md.</u>		ADDRESS	

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# CERTIFICATE OF DEATH

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. AGE OF DECEASED

6. SEX OF DECEASED

7. RACE OF DECEASED

8. OCCUPATION OF DECEASED

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF COURT

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CONSTABLE

21. SIGNATURE OF TOWNSHIP CLERK

22. SIGNATURE OF TOWNSHIP JURY

23. SIGNATURE OF TOWNSHIP COURT

24. SIGNATURE OF TOWNSHIP JUDGE

25. SIGNATURE OF TOWNSHIP SHERIFF

26. SIGNATURE OF TOWNSHIP CONSTABLE

27. SIGNATURE OF TOWNSHIP CLERK

28. SIGNATURE OF TOWNSHIP JURY

29. SIGNATURE OF TOWNSHIP COURT

30. SIGNATURE OF TOWNSHIP JUDGE

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

550

Item 14 Film G209 1-18-57 et

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Wash., D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Esldorf</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1606 Mass. Ave., Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>47X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>F.</b> Last <b>Downs</b>		4. DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-1896</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Hauler</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tom Downs</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>W.W. 1</b>	
17. INFORMANT <b>Francis W. Downs, 2209 Lakewood St.</b>		Address <b>Suitland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 Min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William J. Kurz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William J. Kurz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-14-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cochran Inc. La Plata Md</b>		24a. REC'D BY REGISTRAR <b>DATE 1/11/57</b>	24b. REGISTRAR'S SIGNATURE <b>Julius H. Poney</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
John Doe		Male		45		White		1910		Maryland		Baltimore		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Occupation		Education		Marital Status		Religion		Last Illness		Date of Death		Time of Death		Place of Death		Witnesses		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Teacher		High School		Married		Catholic		10 days		1957		10:00 AM		Home		John Doe, Jane Doe		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JAN 15 1957

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## CERTIFICATE OF DEATH

Reg. Dist. No.

00547/60

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hughesville</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural - Hughesville</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY LAURA LEE FORD</u>				4. DATE OF DEATH Month Day Year <u>JAN. 18 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 10, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Marys Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ABRAHAM BRISCOE</u>				14. MOTHER'S MAIDEN NAME <u>CHARISSA KNIFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Husband - Robert Ford - Hughesville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocardial Heart Dis</u> DUE TO (c) <u>Chronic Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Sept 17, 1955</u> , to <u>Jan 18, 1957</u> , that I last saw the deceased alive on <u>Jan 18, 1957</u> , and that death occurred at <u>8:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Valeh M. Seron</u> M.D.				DATE SIGNED <u>1/18/57</u>			
PHYSICIAN'S NAME (Type) <u>V. M. SERON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Episcopal Cem. New Market Md.</u>		22d. LOCATION (City, town, or county) (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT Funeral Home</u>				ADDRESS <u>under</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>John Poup</u>				DATE <u>JAN 21 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 21 1957

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00548

## 552 CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - WALDORF</u>		LENGTH OF STAY (in this place) <u>LIFETIME</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - WALDORF</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY F HAMILTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 12 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>US-W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 19, 1867</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>McDavid</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Ethel Robey White Plains, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420. IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u>						<u>12 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive heart failure</u>						<u>2 wks.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic heart disease</u>						<u>4 years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August</u> , 19 <u>52</u> , to <u>January</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>57</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Wooddy</u>		M.D. <u>La Plata, Maryland</u>		ADDRESS (Street, city, town, state) <u>12 Jan 57</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-14-57</u>		NAME OF CEMETERY OR CREMATORY <u>Oakland Cem.</u>		LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 16 1957</u>		REGISTRAR'S SIGNATURE <u>Miss M. L. Monroes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1957

1. DECEASED PERSON'S NAME (Last, first, middle)

2. PLACE OF BIRTH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL PLACE

15. SIGNATURE OF INTERVIEWER

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96. SIGNATURE OF OTHER OFFICIALS

97. SIGNATURE OF OTHER OFFICIALS

98. SIGNATURE OF OTHER OFFICIALS

99. SIGNATURE OF OTHER OFFICIALS

100. SIGNATURE OF OTHER OFFICIALS

BUREAU V. 8

JAN 16 1957

RECEIVED

28013072721

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00549

## 55 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>CHARLES</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LA PLATA</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS' MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HUGHESVILLE</u> STREET ADDRESS (If rural give location) <u>ROUTE #5</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Gary</u> (Middle) <u>Keith</u> (Last) <u>LAW</u>			4. DATE OF DEATH (Month) <u>JANUARY</u> (Day) <u>27</u> (Year) <u>1957</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Dec. 2 1955</u>	9. AGE last birthday <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>	IF UNDER 2 HRS. Hours <u>1</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Larnie L. Law</u>			14. MOTHER'S MAIDEN NAME <u>Helen M. Hill</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Larnie L. Law</u> <u>Hughesville Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>286.0 IMMEDIATE CAUSE (A) <u>BRONCHOPNEUMONIA</u></u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>CELIAC DISEASE</u>							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>JANUARY</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JANUARY 27</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John N. Griffin</u> M.D.		ADDRESS (Street, city, town, state) <u>Box #65, HUGHESVILLE MD. 1/28/57</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Jan. 29 1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>			
24. REC'D BY REGISTRAR <u>JAN 31 1957</u>		REGISTRAR'S SIGNATURE <u>Julia Posey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>			
				ADDRESS <u>Waldorf Md.</u>			



1

INSTRUCTIONS

TO A **NDING PHYSICIAN OR HOSPITAL**: The law requires that the death certificate be **ated within 24 hours** after death. The **from** copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR**: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00550

## 551 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>LA PLATA</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>LA PLATA</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physicians Memorial Hosp.</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Jonah J. NEWTON</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 28 19 57</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W-S-W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov 29 1885</i>	9. AGE last birthday <i>71</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Mfg.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Jewelry</i>		11. BIRTHPLACE (State or foreign country) <i>MASS.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>ALONZO NEWTON</i>				14. MOTHER'S MAIDEN NAME <i>MIRANDO A. POKTON</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i>		16. SOCIAL SECURITY NO. <i>135 10 0645</i>		17. INFORMANT & ADDRESS <i>BESSIE E. NEWTON LA PLATA, MD.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <i>Cardio-respiratory failure</i>						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Myocardial infarction</i>						10 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Atherosclerotic heart disease</i>						3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Tumor of Rt kidney</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June</i> , 19 <i>52</i> , to <i>28 Jan</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>28 Jan</i> , 19 <i>57</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Storwood</i>				ADDRESS (Street, city, town, state) <i>La Plata, Md.</i>		DATE SIGNED <i>28 Jan 57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-30-57</i>		NAME OF CEMETERY OR CREMATORY <i>Mt Rest Cem.</i>		LOCATION (City, town, or county) (State) <i>LA PLATA, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Julia Posey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>HUNT, FUNERAL HOME - WALDORF, MD.</i>		ADDRESS	
DATE <i>JAN 31 1957</i>							

# CERTIFICATE OF DEATH

NAME OF DECEASED <b>Charles A. Newton</b>		DATE OF BIRTH <b>Nov 24 1887</b>		PLACE OF BIRTH <b>Albany, New York</b>	
SEX <b>Male</b>		RACE <b>White</b>		EDUCATION <b>High School</b>	
OCCUPATION <b>Retired</b>		MARRIAGE <b>Married</b>		DATE OF MARRIAGE <b>1910</b>	
NAME OF WIFE <b>Albany, New York</b>		DATE OF DEATH <b>Jan 31 1957</b>		PLACE OF DEATH <b>Baltimore, Md.</b>	
CAUSE OF DEATH <b>Heart Disease</b>		MANNER OF DEATH <b>Natural</b>		SIGNATURE OF PHYSICIAN <b>Dr. J. H. Smith</b>	
SIGNATURE OF DECEASED <b>Charles A. Newton</b>		SIGNATURE OF WIFE <b>Albany, New York</b>		SIGNATURE OF NEAREST RELATIVE <b>Dr. J. H. Smith</b>	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A GRAVE SPACE IN ANY CEMETERY IN THE STATE OF MARYLAND. IT IS NOT VALID FOR THE PURPOSE OF OBTAINING A GRAVE SPACE IN ANY CEMETERY OUTSIDE THE STATE OF MARYLAND. IT IS NOT VALID FOR THE PURPOSE OF OBTAINING A GRAVE SPACE IN ANY CEMETERY IN ANY OTHER STATE.

**RECEIVED**  
JAN 31 1957  
**BUREAU V. 8**



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00551

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Charles</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cobb Island, Md.</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Cobb Island</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>James Andrew Shymansky, Jr.</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>1 4 1957</b>											
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 12, 1942</b>		<b>9. AGE</b> (In years last birthday) <b>14</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Student</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>James Andrew Shymansky</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Spalding</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <b>Mr James A Shymansky Cobb Island</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Gun shot wound left chest</b> (c), stating the underlying cause lost, DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <b>1-4-57</b> <b>1-4-57</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>Gun discharged accidentally (his)</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>11-4</b> 1957 p. m.				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>River Shore</b>				<b>20f. (City or town) (County) (State)</b> <b>Cobb Island, Charles, Md.</b>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</b>															
<b>ACTUAL SIGNATURE</b> <i>E. J. Edelen</i> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>												<b>DATE SIGNED</b> <b>1-5-'57</b>			
<b>EXAMINER'S NAME (Type)</b> <b>E. J. Edelen, M.D.</b>												<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>												<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			
<b>22b. DATE THEREOF</b> <b>1-7-57</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Ghost</b>				<b>22d. LOCATION (City, town, or county) (State)</b> <b>Issue Md</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Crehart Inc Leplante</i>						<b>24a. REC'D BY REGISTRAR</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <i>Julia H. Barry</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 10 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**556 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00552  
100

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>PAUL ADRIAN Sweetney</u> First Middle Last <b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>N</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1924</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>32</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <u>19</u> <u>1957</u> Month Day Year	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Albert Sweetney</u> <b>14. MOTHER'S MAIDEN-NAME</b> <u>LUSSIE DUCKETT</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>517 028 4580</u> <b>17. INFORMANT</b> <u>Albert Sweetney</u> Address <u>Bryantown MD.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exposure</u> <u>932.9</u> DUE TO <u>Alcoholism and</u> Conditions, if any, which gave rise to immediate cause (b) <u>lying in snow sh. at 10° temp.</u> (c) <u>1-19-57</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1-19-57</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Chas.</u> <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <u>E. J. EDELEN</u> <b>EXAMINER'S NAME</b> (Type) <u>E. J. EDELEN</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>1-22-57</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Mary's Cem.</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Bryantown MD.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hunt Fennel Home</u> ADDRESS <u>Wachow, MD.</u> <b>24a. REC'D BY REGISTRAR</b> <u>JAN 23 1957</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Julia Pascoe</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is mostly blank with some faint, illegible markings.

**RECEIVED**  
JAN 23 1957  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00553  
105

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>E.</b> Last <b>Walker</b>		4. DATE OF DEATH Month <b>1</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29, 1903</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Walter Crosen</b>	
14. MOTHER'S MAIDEN NAME <b>unk</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Calvin L. Walker</b> Address <b>Center St SE Washington, DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (b) <b>260X</b> DUE TO (c) <b>260X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of Diabetes untreated</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>E. J. Edelen</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. J. Edelen, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1-17-'57</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-19-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Huntt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR <b>21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>M. L. Monroe</b>	



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